

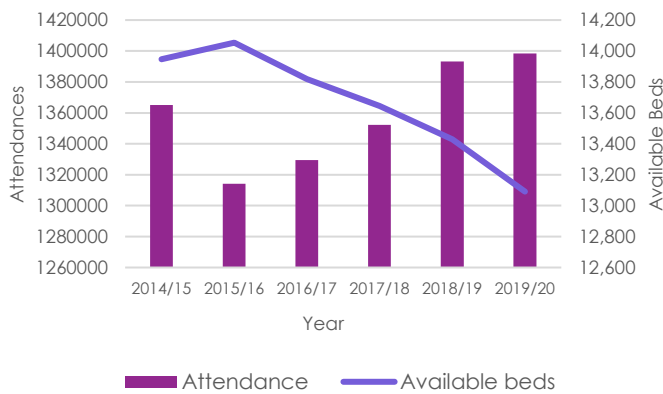
The Royal College of Emergency Medicine (RCEM) Written submission for the Health, Social Care and Sport Committee

**Seasonal Planning and Preparedness**

At present, Emergency Departments (EDs) are experiencing record breaking levels of demand. Performance data published for August 2021 revealed that 75.4% of patients waited more than four hours to be admitted transferred or discharged in major departments – the worst performance on record. Even more alarming is that 5,460 patients were delayed by eight hours or more and 1,410 patients by 12 hours or more. It is likely we are going to battle our toughest winter on record in EDs as Summer 2021 fared worse than every winter gone before. RCEM recently publish a [Demand Explainer](#), which delves deeper into the reasons behind recent demand.

As Graph 1 demonstrates, demand has continued to increase year on year, all in the context of a shrinking bed stock; over one thousand staffed beds have been taken out the system in the last decade and more have been removed from the system due to Infection Prevention and Control measures brought in during the pandemic. This has led to patients often waiting on a trolley for hours for an available bed and having to receive care in a corridor. This reality is inhumane and unacceptable and can cause significant distress to both patients and staff.

**Graph 1. Yearly attendances vs staffed available beds**



Furthermore, there is a wealth of compelling evidence that discusses the correlation between long waits and increased risk of avoidable mortality. The Getting It Right First Time (GIRFT) [report](#) identified this link using data from England. The effect is strong and consistent, and it is extremely likely that these associations would be seen across the devolved nations of the UK as the healthcare systems and patient characteristics are largely similar.

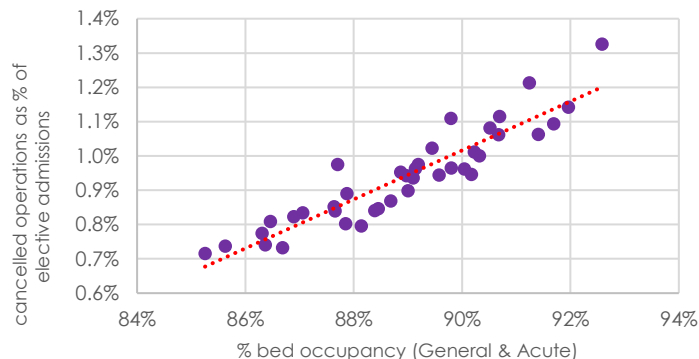
The data show that for every 67 patients waiting 8-12 hours, one of them to will come to avoidable harm. To put this into context, in 2021 so far in Scotland there have been **231 excess deaths** directly caused by a long wait due a crowded ED (January – August). What these figures don't show is the harm that those waiting even longer may have come to, and those that did not die but nonetheless suffered harm due to the delay they experienced. Crowding has always been unconscionable, but these figures lay bare the reality; lives are being lost due to an issue that could be eradicated for good if given sufficient resources.

One of the main factors behind exit block and poor flow is an inefficient discharge process. While medically fit to leave, patients may need help to recover in the form of a social care package, which may not be immediately available meaning their hospital bed is unavailable to the next patient. Similarly, a crowded ED disrupts patient flow at the front of the hospital too. Patients arriving by ambulance are now routinely delayed and ambulance stacking takes place on a daily basis. This not only means the patient stuck in the ambulance is at risk of harm, but it also means the ambulance cannot return to the community where there are patients requiring that resource.

Demand in and of itself is not the issue, it is the lack of capacity to cope with said demand and subsequent poor patient flow. What ensues is a system fighting for the same pool of bed stock. Most

notably, it is common for seasonal pressures to temporarily disrupt elective care. Graph 2 shows that as general and acute bed occupancy rises, so do the number of cancelled operations. The recovery of the elective backlog should be a priority, but it cannot be considered in isolation. If Unscheduled care cannot cope this winter, elective care will once again have to be paused.

**Graph 2: General and Acute Bed Occupancy and Cancelled Operations**



GIRFT analysis was done to determine the adequacy of ED capacity based on the interplay between:

1. the number of senior medical staff per shift;
2. the ratio of major cubicles and resus cubicles to attendances; and
3. hospital bed occupancy, i.e., the number of available beds.

Unsurprisingly, patients spend less time in EDs whenever all three variables are better than average. Departments with sufficient senior staff to make key decisions, sufficient cubicles to accommodate patients, and sufficient hospital beds for admissions have the lowest patient times in the ED. Counterintuitively, the worst combination is not the opposite of the best. The worst combination is to have a lower number of senior medical staff but an above average number of cubicles. This effectively creates an ED with the worst ratio of doctors to patients, but little hospital incentive to move patients in a timely fashion because ED space is not at a premium.

Capacity cannot be discussed without considering staffing numbers. RCEM recommends that the safe staffing of EDs should be based around a ratio of one Whole Time Equivalent (WTE) consultant per 4000 annual attendances. Table 1 below shows that despite the number of Emergency Medicine (EM) consultants increasing at a constant rate every year, the expansion in numbers is still not happening fast enough to cope with the level of demand. This results in continued understaffing in departments. RCEM's first ever [Scotland Workforce Census](#) showed that at present there is a shortfall of roughly **130 consultants** in Scotland. As [evidence shows](#), understaffing means the EM workforce consistently reports the highest levels of work intensity of all the medical specialties, leading to high rates of attrition from both training and the specialty, only further exacerbating the issue.

Year	WTE Consultants	Attendances at Type 1 EDs	Attendances per WTE Consultant
2016/17	215	1,329,488	6,183
2017/18	222	1,352,331	6,091
2018/19	228	1,393,238	6,097
2019/20	236.5	1,398,441	5,913

The seasonal effect is not new, and it is not unpredictable, yet it forces us to generate and focus on short term solutions. This is certainly going to be necessary this year in the form of freeing up capacity and prioritising patient flow. Effort must be made to ensure that those ready for a ward or to be discharged can be done so in a timely manner.

However, looking forward, the Scottish Government must set out a long-term plan to guarantee that the system has the capacity to accommodate fluctuations in demand year-round. Expanding

the workforce is a crucial step in increasing overall capacity to keep up pace with demand. Only then can we start to tackle winters in a cost-effective, safe and sustainable manner.